



WISCONSIN

DEPARTMENT OF WORKFORCE DEVELOPMENT

Division of Workforce Solutions
Bureau of Work Support Programs

**TO: Economic Support Supervisors
Economic Support Lead Workers
Training Staff
Child Care Coordinators
W-2 Agencies**

FROM: Stephen M. Dow
Policy Analysis & Program Implementation Unit
Work Programs Section

BWSP OPERATIONS MEMO

No.: 01-46

File: 2799

Date: 07/23/2001

Non W-2 ☒ **W-2** ☐ **CC** ☐

PRIORITY: High

**SUBJECT: LONG TERM CARE FUNCTIONAL SCREEN ELIGIBILITY
DETERMINATION CORRECTIONS**

CROSS REFERENCE: Please refer to other Operations Memos discussing Long Term Care (00-79), Family Care (00-81), SSI Waiver (00-80).

Pilot counties should also reference training and clarification documents provided to them.

EFFECTIVE DATE: Immediately

PURPOSE

The attached memo from Judith Frye explains the process for economic support (ES), Resource Centers (RC) and Care Maintenance Organizations (CMO) to redetermine and adjust certain incorrect functional screen level of care determinations. Please review the entire memo. Section C, titled "The Economic Support Unit Should", explains the specific ES role in making the adjustments.

NOTE: Fond du Lac, La Crosse, Portage, Milwaukee and Richland ES agencies will be sent hard copy of the "CMO Members Status Change With ADLFI" report specific to their county and CMO population. Please work with your RC and CMO to adjust these cases.

Thank you for your attention and cooperation with this effort.

CONTACT

DES CARES Information & Problem Resolution Center

Email: carpolcc@dwd.state.wi.us
Telephone: 608-261-6317 (Option #1)
Fax: 608-266-8358

Note: Email contacts are preferred. Thank you.



**Department of Health and Family Services
Office of Strategic Finance**

PO Box 7850
Madison WI 53707-7850
Phone (608) 266-3816
Fax (608) 267-0358

Date: July 11, 2001
To: CMO and Resource Center Managers
From: Judith E. Frye, Director
Center for Delivery Systems Development
Subject: LTC FS Eligibility Determination Corrections

We recently learned that, due to a programming error in the Long Term Care Functional Screen (LTCFS) eligibility logic, a number of screens have given incorrect levels of care that affect the eligibility status of the individuals who were screened. Specifically, several screens that had adaptive aid equipment checked in the Activities of Daily Living section were incorrectly scored and the applicants given incorrect determinations of eligibility. For example, if the Walker or Quad-Cane and Wheelchair or Scooter adaptive aid equipment was checked under an applicant's Mobility ADL, rather than scoring as just one ADL deficit, it was counted as three ADLs. As a result, some applicants were given a higher level of care determination than they actually should have received.

This problem with the programmed LTC Functional Screen logic has been corrected with an updated version of the screen issued to pilot Resource Centers in May 2001, and is no longer affecting new screens. However, the screens of those people who received incorrect determinations of eligibility based on the incorrectly programmed logic need to be re-evaluated. Incorrect eligibility determinations are of serious concern for a number of reasons. If Family Care eligibility at the Comprehensive - Nursing Home level is affected, this could also affect a consumer's eligibility for Medicaid services. If a consumer's eligibility at the Comprehensive level is affected, and they are non-MA, they are not entitled to the Family Care benefit.

We have simulated corrections to those screens affected by the eligibility logic error to establish what the correct eligibility determinations would have been. These simulated corrections are not official and have not been made to the Family Care database. Before any changes in eligibility are made official, we need all CMOs to review the screen information of affected consumers to confirm the accuracy of screen data and to re-screen if any information is inaccurate.

Enclosed you will find a report of: (1) CMO members who were affected by the programming error in the LTCFS logic and (2) individuals who do not show up on MMIS as being CMO members but who received a LTCFS with an erroneous level of care. The report indicates old eligibility determinations prior to the corrected program logic and simulated corrected functional eligibility determinations. For all consumers in this report, Comprehensive-Nursing Home level of care was lost. In most cases, consumers dropped from Comprehensive-Nursing Home to Intermediate level of care. Included in the report for CMO members are a note field and an "adjustable? LOC" check box. As CDSD staff reviewed these screens, every effort was made to identify possible screener errors or omissions that, if corrected, could affect eligibility determinations. If such errors or omissions were found, the "adjustable? LOC" box is checked and an explanation is given in the note field. As CMOs review the screen information of these affected consumers, they should refer to the notes and update the screen as appropriate. We anticipate that at least some the screens where the "adjustable?LOC" box is checked will, when corrected, yield a Comprehensive or Comprehensive-Nursing Home level of care.

The first part of the report includes:

MA NUM:	The affected consumer's Medicaid number
LASTNAME:	The consumer's last name
oldELI:	The consumer's old eligibility determination for Family Care (prior to the eligibility programming correction)
corELI:	The consumer's simulated corrected eligibility determination for Family Care
Notes:	Notes on the screen with regard to current status and potential need for review and corrections
MA Status:	Consumer's Medical Assistance code (with an indication of whether the person is at risk to lose MA)
cost:	The consumer's average historical monthly service cost based on the last three months of services received in 2000 (for some consumers, costs were not known)
recert:	The consumer's MA recertification date
adjustLOC:	Checked box indicates that based on CDSD review, this consumer's screen could potentially be adjusted to affect LOC.

In order to correct these erroneous eligibility determinations, the following should occur:

A. The CMO should:

1. First, review those screens that have the adjustable LOC box checked and have those individuals re-screened, using the note column as a guide. Through a re-screen, the consumer's level of care determination may be adjusted.
2. For those screens that do not have the adjustable LOC box checked, re-screen based on the MA recertification date, unless the recertification date is more than 3 months away, in which case these cases should be re-screened by October 15, 2001.
3. Check to see whether any of the individuals in the second part of the report (those not showing on MMIS as CMO enrollees) have been recently enrolled. These individuals should also be re-screened based on the MA recertification date, unless that date is more than 3 months away, in which case they should be re-screened by October 15, 2001.
4. Inform ES of any changes in LOC so they can re-run the eligibility determination. ES will redetermine eligibility, and notify the CMO of the results. ES will not put the case in pend status, but will wait for 10 business days for the CMO or RC to inform them of any further changes or that ES should confirm the new eligibility status. If ES does not hear from CMO or RC within 10 business days, ES will go ahead and confirm the new eligibility status.
5. Once ES has confirmed new eligibility status, ES will notify the CMO of the results. Confirmation of the new eligibility status will result in a new eligibility notice to the consumer. If the person is no longer eligible for Family Care, ES will set the date of loss of eligibility according to adverse action logic. ES will notify the CMO of the date eligibility is lost, which is the same as the disenrollment date.
6. Consumers who will lose MA status and face financial hardship, or who will lose Family Care eligibility or entitlement should be referred to the Resource Center for long term care options counseling.
7. For those screens on which you have clinical questions, please contact Alice Mirk at 608-261-8877 or Rachel Smith at 608-266-3372.

B. The Resource Center should:

1. Check the second section of the report, which lists individuals not showing on MMIS as CMO enrollees. If any of these individuals are currently considering CMO enrollment, they will need to have a new LTCFS to accurately determine functional eligibility.
2. Provide long term care options counseling to any of individuals who are referred because of a change in eligibility status. This will most likely include consumers who may be losing their Medicaid card and/or access to the Family Care benefit.

C. The Economic Support Unit should:

The ES worker will need to review the first part of the report to identify any cases that show correct eligibility (corELIG) as C with no nursing home level of care, but with a waiver med stat code. An individual cannot qualify functionally for community waivers without having a functional nursing home level of care. Check with the CMO to obtain the correct information, enter the new functional information and run eligibility as described below.

For most of the cases in the first part of the report, the ES worker will need to wait for the new functional eligibility level from the CMO worker and then follow the steps described below.

NOTE: While we expect that all changes to functional eligibility, both community waiver program and Family Care, will mean either no change or a decrease in benefits, we have included instructions in the eventuality that the change could show a functional eligibility that could increase their benefits.

1. If the change in Community Waiver functional eligibility is from Yes to No (nursing home level of care is now 'N'), enter the change in Waiver Functional eligibility on ANCW with an effective date of the month the change was reported to you by the CMO.
2. If the change in Family Care functional eligibility is from C to I, or C to N or I to N, enter the change in Family Care functional eligibility on ANFR with an effective date of the month the change was reported to you by the CMO.
3. For both #1 and #2, ES will redetermine eligibility, and notify the CMO of the results. If the person is no longer eligible for Family Care, ES will set the date of loss of eligibility according to adverse action logic (the termination date will be the CMO disenrollment date). ES will notify the CMO of the disenrollment date.
4. ES will not put the case in pend status, but will wait for 10 business days for the CMO or RC to inform them of any further changes or that ES should confirm the new eligibility status.
5. If ES does not hear from CMO within 10 business days, they should proceed to confirm the new eligibility status. Confirmation of the new eligibility status will result in a new eligibility notice to the client. Any adjustment to eligibility will follow adverse action logic.
6. Run eligibility for the recurring month for any of these cases that could lead to a decrease in benefits. An adverse action notice of decision must be generated in a timely fashion for any decrease in benefits to occur.
7. For any individuals that become non MA intermediates, do not confirm them as non-MA intermediates. Instead, ES should end Family Care in CARES, according to policy, thus setting the termination date

(the termination date will also be the CMO disenrollment date). Then they should communicate the disenrollment date to the CMO.

8. Do NOT recover benefits paid by Medicaid or Family Care during this time period. These errors were the State's and not those of the local agency or the client. They are not recoverable.
9. In any instance where the change in functional level could mean an increase in benefits, the eligibility worker must enter the change in the month the incorrect functional data was entered and re-run eligibility with dates for the entire time period. This will ensure that the Family Care CMO is paid the appropriate rate back to the month of change and that the client is paying the appropriate cost share, effective according to adverse action logic.

The ES worker must also review the second part of the report. This part of the report lists those individuals who have had a functional screen done in which the incorrect logic may have affected their functional determination, but the individual hasn't yet been enrolled in the CMO. For these cases, determine if the individual's eligibility and enrollment is still being processed. Make sure that the Resource Center redetermines this individual's functional eligibility BEFORE taking any further action on the CARES case. If the 30 day processing clock is running out, extend the processing clock by 10 days and send a notice of decision to the client explaining that the Resource Center needs to re-examine his/her functional eligibility before further action can occur.

All of these consumers will continue to be served at their current status and the CMO will continue receiving reimbursement from the State based on their original level of care determinations until their re-screen is complete according to the timelines noted above. If you have follow up questions or concerns regarding this effort please contact Alice Mirk by phone 608-261-8878 or email mirka@dhfs.state.wi.us, or contact Rachel Smith by phone 608-266-3372 or email smithrr1@dhfs.state.wi.us. Thank you for your assistance.

cc: Monica Deignan
Alice Mirk
Karen McKim
Greg Robbins

Beth Price-Marcus
John Westfall, EDS
Nachman Sharon
James Jones, BHCE